Introduction

This report is from data collected from the West Virginia Domestic Violence Fatality Review Team for the calendar year of 1997. Although, all of the cases reviewed are not necessarily what comes to mind when we think of domestic violence they are all important in assessing the lethality of domestic violence in our State. Inclusion of these "other victims" is a key difference in our study than previous reports. Domestic violence poses a lethal threat not only to victims, but also to those people close to them such as other family members, friends, new partners, law enforcement, and sadly even the children. As a team we felt that looking only at female victims of domestic violence, as many other domestic violence fatality review teams across the United States have chosen to do was not sufficient or truly reflective of the domestic violence in our State.

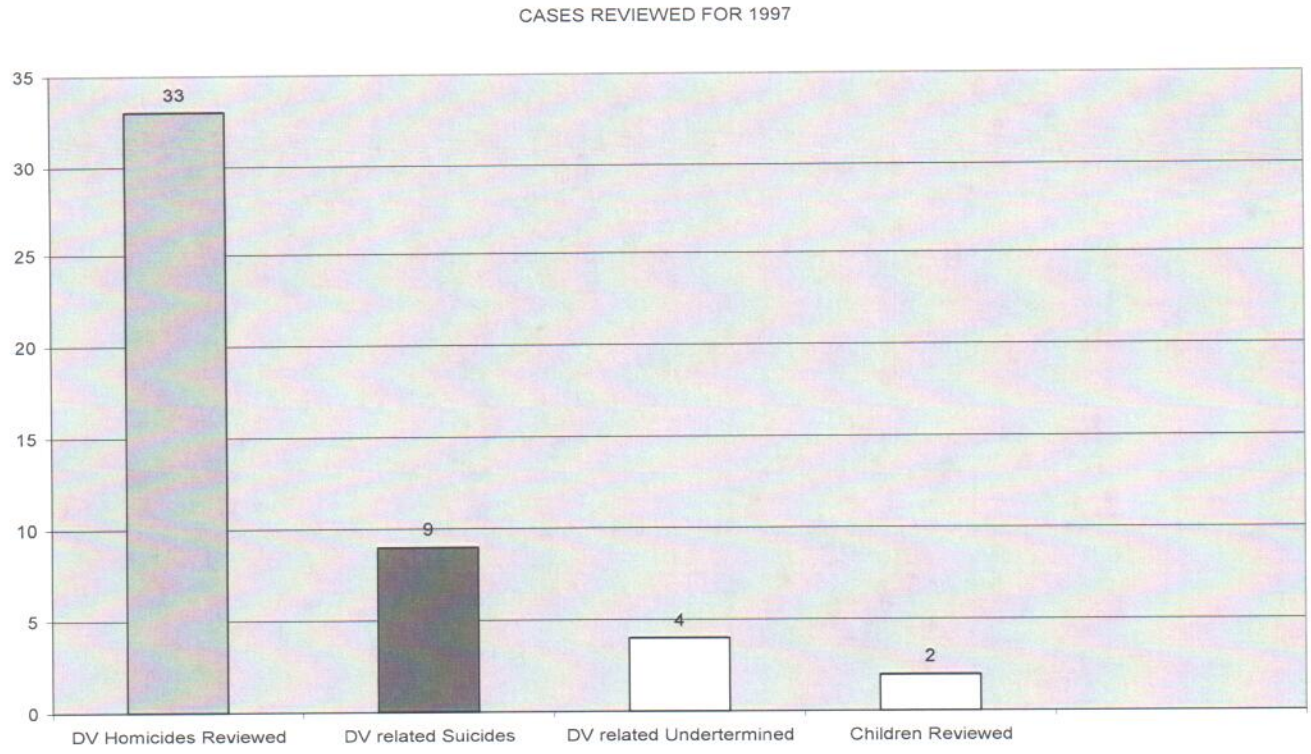
We looked at familial relationships as well as intimate partner deaths. In several cases there were no indications of previous domestic violence. In fact, in two of the most haunting cases which involved multiple homicides and were concluded with suicides of the perpetrators there were no indication of previous domestic violence. However, a majority of the cases had previous domestic violence, either reported or unreported, and it was often disturbing as to how many systems in our State failed to serve and protect these victims. It is not enough for the State of West Virginia to merely count the domestic violence related deaths, we must learn from these tragedies and continuously strive to improve our response to victims of domestic violence. It is not goal of the team to assign blame to any system, rather to identify gaps in those systems so that similar deaths do not have to occur. Domestic violence deaths are 100% preventable. For every person killed by domestic violence, there are thousands of others who are accessing the systems we are reviewing trying to escape the same fate.

Domestic Violence in West Virginia

In 1997 West Virginia was honored to have the lowest crime rate in the nation for the 25th consecutive year according to the Crime in West Virginia 26th Edition report. Yet violent crime rose 2.8 percent from 1996 to 1997 and the murder rate increased 8.7 percent. West Virginia's law enforcement received 9,992 domestic violence complaints in 1997. Of those complaints 9, 662 (96.7%) were investigated. This figure shows a 3.3 percent increase in domestic violence complaints. Of those reported complaints, 32.5 percent of them had filed a previous complaint. Protective orders were violated in 180 of these cases. 3,936 arrest were made from these complaints (39.4%) 5,017 of these complaints were referred (50.2%). It appears that although West Virginia is one of the safest states to live in, we have an alarming rate of domestic violence and domestic homicides in our State.

According to the West Virginia Coalition Against Domestic Violence: Data Summary Report, Fiscal Year 1997-1998, the thirteen licensed domestic violence programs in West Virginia received 21,555 hotline calls, assisted victims in filing 5,771 petitions, served 21,067 adults and 4,572 children. They also provided 35,601 nights of shelter for victims of domestic violence and their children along with 103,931 hours of counseling and advocacy.

According to the West Virginia Department of Vital Statistics 94 homicides occurred in West Virginia in 1997. Eighty of those homicides were adult victims. This preliminary review of the 1997 homicide data by the Domestic Violence Fatality Review Team indicates that 41% (33 of 80) of the state's adult homicides were domestic violence related. According to the Supplementary Homicide Report, by the Bureau of Justice for 1976-1996, intimate murders account for about 9% of the murders which occur nationwide. 60% of the female homicide victims (12 of 20) were domestic violence related as compared to 30 percent nationally according to the Bureau of Justice Statistic Factbook, Violence by Intimates March1998 publication. Fifty-seven percent (8 of 14) child homicides were also domestic violence related. The DVFRT reviewed two of those child homicides, because adult victims were involved in those cases as well. The team also reviewed nine suicides and four adult deaths that were ruled undetermined for a total of 48 cases.



Summary of Data 1997

- 1997 WV had 94 homicides, 80 were adults, 14 children.
- 33 of the 80 adult homicides were domestic violence related.
- 8 of the 14 children's homicides were domestic violence related.
- Reviewed 48 cases, 33 adult homicides, 2 child homicides, 9 suicides, and 4 undetermined deaths.
- 20 victims were female, 28 were male.
- 46 of 48 victims were white.
- 28 of 48 victims were 35 or under. Four were over the age of 60
- 7 were killed by current spouses, none by former spouses, and two from estranged spouses.
- Six of the victim's were killed by one of their children; three were killed by a parent.
- 1 was killed by a former significant other; six others were killed by a current significant other.
- 9 of the cases we reviewed were suicides.
- Four were killed by other family members.
- One was killed by police responding to a domestic.
- Six were killed by a third party
- Four deaths were undetermined.
- 40 of the 48 deaths were caused by gunshot wounds
- 2 were stabbed, 3 killed by blunt force, one by overdose, one from asphyxiation and one from unknown causes.
- 22 of the 55 counties had domestic violence related deaths.

Background

The West Virginia Domestic Violence Fatality Review Team came about as a result of concern over the high number of domestic violence related deaths in the State. The OCME contacted a number of academic, state, and community agencies including the West Virginia Coalition Against Domestic Violence to express desire for a mechanism or team to be put in place to examine the circumstances of these deaths. Out of that initiative a multi-disciplinary team was brought together and met for the first time in January of 1999, to discuss the feasibility and need for a domestic violence fatality review team in the State of West Virginia.

This multi-disciplinary professional group continued to meet for the next two years to establish the WVDVFRT. During this time they created a draft of a data collection tool, which is being finalized now, a problem statement, mission statement, goals and objectives for the team. Funding was also an issue and in the budget year 2001 for the State, the medical examiner's office was able to add the domestic violence and child fatality coordinator positions to their budget.

In November 2001 a part time coordinator for the WVDVFRT was hired and the team became a functioning review team. The team coordinator's position was funded through the medical examiner's budget.

Since the 1990's, domestic violence services have expanded and several public awareness campaigns regarding domestic violence have been launched and completed. These expansions and campaigns notwithstanding, it appears a reliable mechanism or process to identify and examine domestic violence fatalities to prevent future similar deaths needed to be established. Recent high profile domestic violence fatality incidents serve as a stark example of the absence of reliable systems.

Until the establishment of the DVFRT in the state of West Virginia there was no single repository that collected information on domestic violence related fatalities.

The DVFRT Team

- Chief Medical Examiner, Chair

- Coordinator
- 4 Prosecuting Attorneys
- 2 State Police Officers
- Deputy Sheriff
- 1 Police Officer from a local municipality
- Two domestic violence advocates
- One director of a licensed domestic violence program
- A representative from the West Virginia Coalition Against Domestic Violence
- Coordinator for the Child Fatality Review Team
- Bureau of Public Health and Statistics and Epidemiology Representatives
- State Medical Association Director
- Child Protective Services Program Director
- Adult Protective Service Program Director
- Office of Behavioral Health Counselor
- Medical Social Worker
- Nurse
- Division of Corrections Representative
- Researchers

Problem Statement of the WVDVFRT

There is limited understanding of the dynamics of domestic violence related fatalities, either in regard to risk factors or causes, or to long term effects upon the victims and their families.

Most importantly, the phenomenon of domestic violence presents core issues for many public safety and public health agencies which provide social services to our citizens. Until the development of the WVDVFRT there was no comprehensive, multi-disciplinary approach toward studying this problem to review the effectiveness of public service agencies, courts and other systems responsible for serving domestic violence victims. Even though perpetrators of domestic violence ("fatalities") are identified and charged through the criminal justice system, there is little basic research into the factors which directly and indirectly contribute to fatal violence, or the recurrent patterns of case circumstances that might be avoided by the development of effective public health and public safety initiatives.

Mission Statement of the WVDVFRT

It shall be the work of the Domestic Violence Fatality Review Team to provide multidisciplinary investigation into the phenomenon of domestic violence related fatality in order to enhance public safety and well being, by multidisciplinary study and analysis of domestic violence related fatality, by sharing information and insights gleaned through such study with legislative, public safety and public health agencies throughout our state.

Goal of the WVDVFRT

Provide accurate and timely information to the legislators and public safety and public health officials in the State of West Virginia, to decrease the incidents of domestic violence and mitigate its effects upon the citizens of our state.

Objectives

1. Develop and understanding of both the phenomenon of domestic violence related fatality and how public safety and public agencies respond to such violence.
2. Prepare an annual analysis of state justice and community service systems intervention and prevention effectiveness.

3. Prepare a report for policy makers regarding fatality dynamics and those community practices which enhance prevention and provide more effective intervention.
4. To provide advocacy for changes to criminal justice, public safety and public health agencies in order to protect the health and safety of our citizens.

What is Domestic Violence Fatality in West Virginia?

The term "domestic violence" (also termed family violence, domestic abuse or family violence) is defined in West Virginia Code §48-2A-2 as the occurrence of one or more of the following acts between family or household members (1) Attempting to cause or intentionally, knowingly or recklessly causing physical harm to another with or without dangerous or deadly weapons; (2) Placing another in reasonable apprehension of physical harm; (3) Creating fear of physical harm by harassment, psychological abuse or threatening acts; (4) Committing either sexual assault or abuse; and (5) Holding confining, detaining or abducting another person against that person's will. Fatalities (homicides and suicides) resulting from domestic violence related injuries among the following family or household members who are 18 years of age or older are covered: current or former spouses, current or former sexual partners, persons living as spouses, persons who have formerly resided as spouses, parents, children and step children, persons who are dating or have dated, persons who are presently residing or co-habitating or in the past resided or co-habitated together, a person with whom the victim has a child in common; or other persons related by blood or marriage.

Through the utilization of broader criteria for purposes of our reviews we looked at more than intimate partner fatalities. We looked at murder of friends, police officers, family members, undetermined deaths, suicides and third party deaths that could be directly related to domestic violence.

What is a Domestic Violence Fatality Review Team?

The criminal justice system normally investigates domestic violence fatalities and identifies and charges perpetrators, however these investigations do little if anything to review the effectiveness of systems responsible for serving those vulnerable to domestic violence and death. Using the foundation of a public health model of identifying prevention and intervention strategies based on detailed examination of a relatively small number of fatalities, DVFRTs are a means of establishing more reliable mechanisms to prevent future death and injury from domestic violence. DVFRTs facilitate the examination of the events leading up to a fatality by neutral observers from

the perspective of improving future response and shared responsibility. Websdale, et al., characterize the use of DVFRTs as a move from a "culture of blame" in which high profile domestic violence fatalities result in editorials, lawsuits and legislative hearings to a "culture of safety" in which systems are reviewed through the lens of accountability (see reference 5).

Purpose of DVFRT

The principle purpose of any fatality review teams is to reduce deaths and injuries through identification and subsequent rectification of problems in any system that may have contact with those vulnerable to those deaths and injuries. This includes the delivery of multiple services to families including health care systems, civil and criminal systems and other related social service agencies.

Systematic reviews have the potential to reveal missed opportunities for stronger more effective interventions prior to the fatality. Systematic examination of the circumstances that precede a domestic violence related fatality can be a means to learn more about how the justice and social services systems respond to domestic violence in our state.

DVFRT's reviews seek to identify all domestic violence-related deaths in the State and further wish to identify those which have previously gone uncounted. Identifying these deaths can lead to recommendations for changes in investigations, autopsy procedures and records keeping in order to more adequately reflect the toll of domestic violence. The objective of the WV Domestic Violence Fatality Review project is to affect systematic change that will also identify domestic violence-related deaths that have previously been uncounted.

Crime statistics such as those listed at the beginning of this report are useful for identifying at domestic violence fatalities, but they also have limitations. When the methods of tracking crimes do not take into consideration circumstances surrounding a death, they do not reliably identify all domestic violence related deaths. When the focus is only on the relationship of the victim and perpetrator often the deaths of law enforcement officers, bystander, advocated or the victim's friends and family are not attributed to domestic violence.

According to the 26th Edition of Crime in West Virginia, 1997 the state of West Virginia had 78 homicides, according to the Department of Vital Statistics there were 94. The crime in West Virginia data listed 25 domestic homicides. The DVFRT identified 33. This could be due to many factors, the

Crime in West Virginia publications rely on reported information from all law enforcement agencies in West Virginia, however not all reports are forwarded to the Uniform Crime Report division. Also, if the relationship between the victim and the perpetrator was not known at the time of the report but later established the statistics are not updated to reflect the relationship. Further if a death was classified as undetermined or accidental and were domestic violence related they would not be included in the data collected by the West Virginia State Police for the report. Until the establishment of the DVFRT there was no single repository that collected information on domestic violence related fatalities.

Further crime statistics do not identify non-homicidal domestic violence related deaths such as suicides. Many victims of abuse, as a result of despair will commit suicide. Also, many perpetrators of domestic violence will commit suicide as a final attempt of control, often at the point the victim has decided to leave the relationship. In the 1997 data reviewed by the West Virginia Domestic Violence Fatality Review Team, nine cases were suicides. Three of these were women, all of which had a history of being abused. Three were men who killed themselves after an argument of when told the relationship was over two were men who committed suicide after they killed their families, and one after he had killed his girlfriend. In two cases that were undetermined a woman with a history of being a victim took an overdose of medication, a second case with an undetermined manner of death, the girlfriend age 16 and eight months pregnant states that during an argument her 29 year old boyfriend shot himself while she held him and pleaded for him to stop.

How Effective Are Domestic Violence Fatality Review Teams?

Domestic violence fatality review teams are a relatively recent addition to the work of preventing and reducing domestic violence. At this time, there is no data about the impact of the review teams on fatality rate. However, states and communities that use fatality review teams report that their findings are beginning to impact public policy and legislation. For example, based on the results of their review team, Hawaii is examining the kinds of lethality assessments used, the content and language of child custody and visitation orders, the conditions set forth in civil protection orders, law enforcement protocol regarding recovery and searches for firearms and other weapons, and the law enforcement response to violations of protection orders and bail conditions, and the length and conditions of incarceration. (See reference 1). In 1999 the Nevada Legislature passed bills that 1) provide protective custody for children when one parent is arrested for killing the other, and 2)

restrict the ability of a parent convicted of murdering the other parent to gain custody of the children. The legislature was prompted by testimony from the chair of the Washoe County Domestic Violence Fatality Review Committee.

The West Virginia Domestic Violence Fatality Review Team

The DVFRT is built on a public health model with a goal toward **prevention.** The DVFRT shall review all deaths of victims or suspected victims of domestic violence including suicides: eighteen years and older, who are residents of this state, in order to identify trends, patterns and risk factors. If we are better able to understand how and why fatalities occur we have a better chance of preventing future deaths. The team will provide statistical analysis regarding the causes of domestic violence fatalities; promote public awareness of the incidences and causes of domestic violence fatalities, including recommendations for their reduction.

The DVFRT has determined that only cases of domestic violence related homicides and suicides that are closed (no pending or on-going legal action) will be reviewed. Resources for identifying domestic violence related fatalities may include but are not limited to the following:

- Medical Examiner's Office
- Law Enforcement
- Vital Statistics
- Newspaper Clippings
- DHHR Social Services
- Courts
- Prosecuting Records
- Licensed Domestic Violence Programs
- Health Care Facilities- Medical Records

Confidentiality is very important and every measure is taken to ensure the confidentiality of the data. Each member of the team will be required to sign a *Confidentiality Agreement Form (Attachment A)* which indicates that they agree not to discuss information discussed during the meeting or contained in agency records, reports of investigations or resulting staff reports.

Data collection is coordinated by one person to maintain consistency and confidentiality. The team coordinator will be responsible for obtaining information from various agencies on hard copy. The process of data collection consists of a representative from each agency brings the information to the review meetings and serves as a member of the team.

Once the data has been collected the hard copy forms will be entered into a database without personal identifiers of anyone involved in the incident of the investigation. Once the data has been entered and cleaned, the hard

copies will be stored for one year in a locked filed cabinet and then shredded. A copy of the draft of the data collection tool is attached. (Attachment 2).

The team meets bi-monthly and reviews an average of eight cases per meeting.

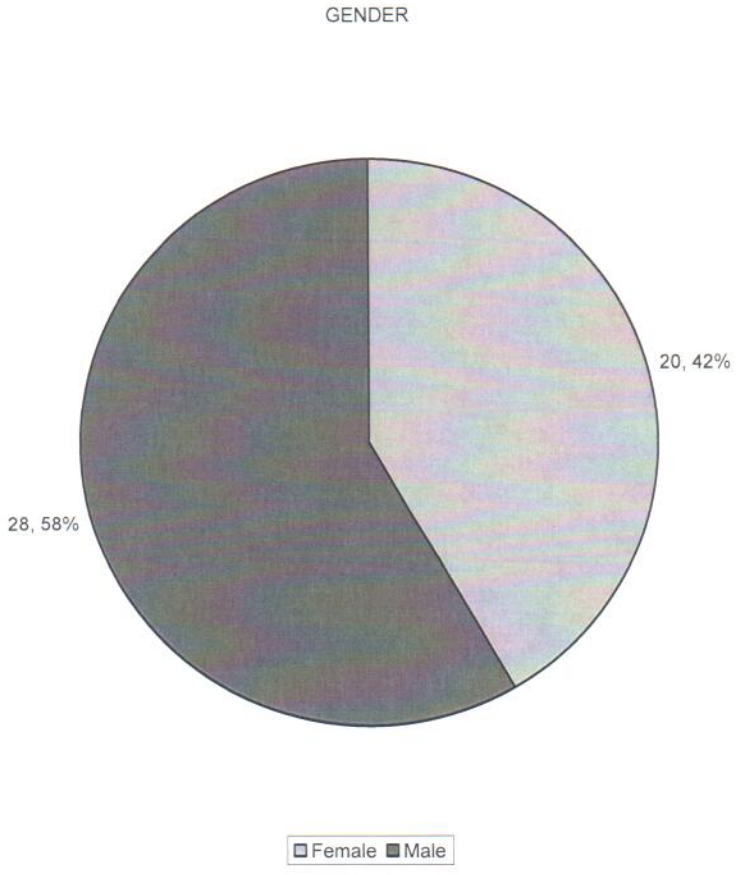
1997

DVFRT

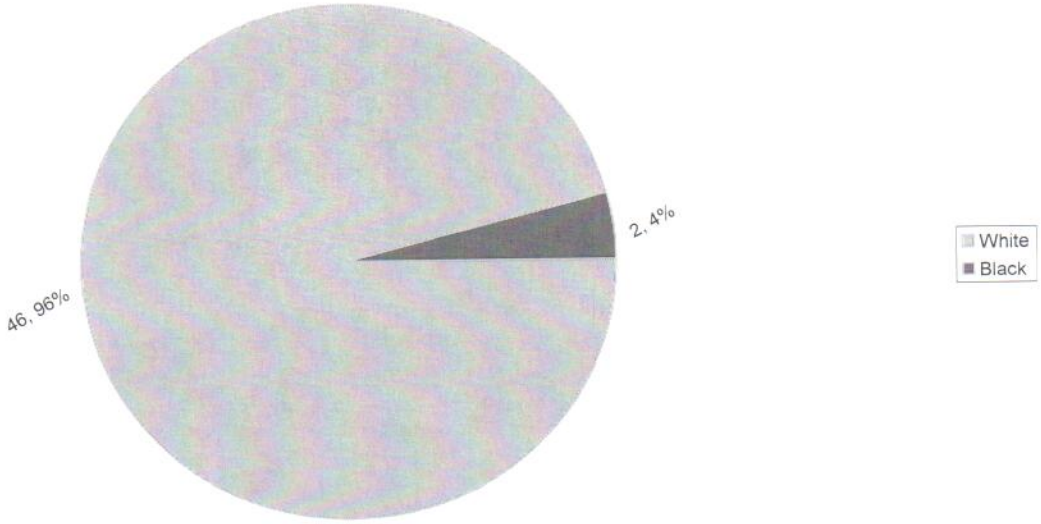
DATA

The DVFRT reviewed a total of 48, fatalities for the 1997 year. Thirty-three of those cases were homicides. Twenty of which the decedent was male and thirteen were female. Nine suicides were also reviewed, which includes six male victims and three female victims. The team also looked at two child homicides due to the fact they were part of an adult homicide/suicide case and four adult deaths that were classified undetermined.

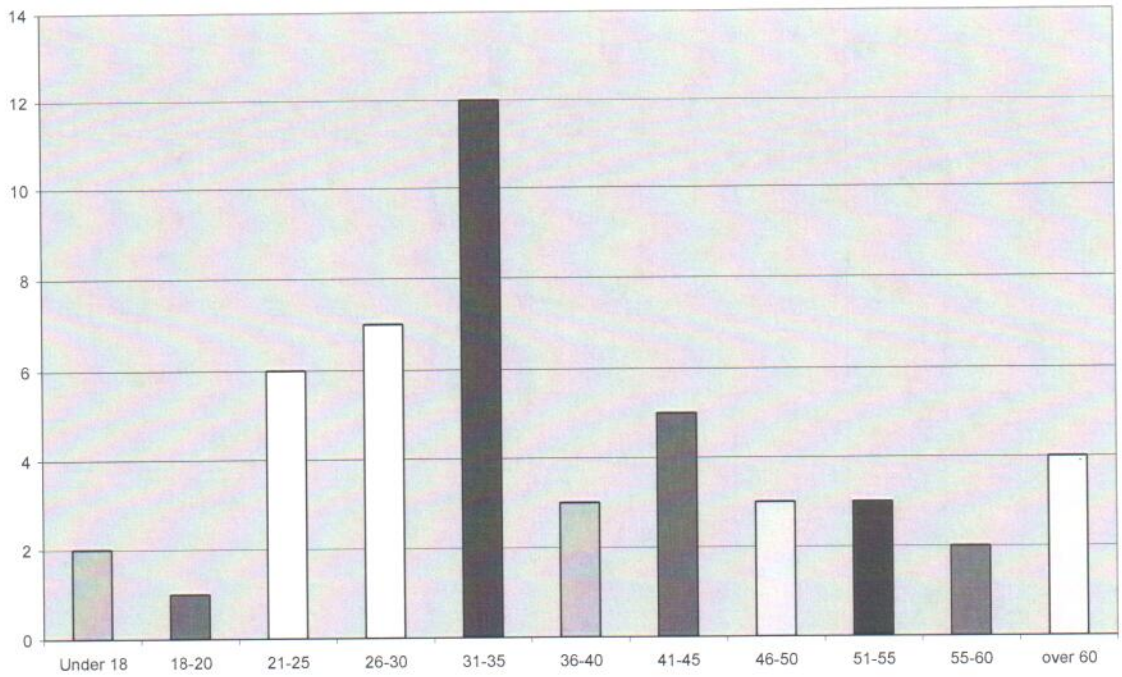
We found that 41% of all 1997 adult homicides in the state were domestic violence related. Of the cases the DVFRT reviewed for 1997, 20 of the 48 fatalities were female. This number represents 42% of the total reviews. 28 (58%) were males. Ninety-six percent of the cases the team reviewed were Caucasian American, four percent were African Americans. No other race was represented in the review. Twenty-eight (58%) of the fatalities were age thirty five or under. With the greatest number, twelve, falling in the 31-35 age bracket. Four of the victims were over the age of 60.



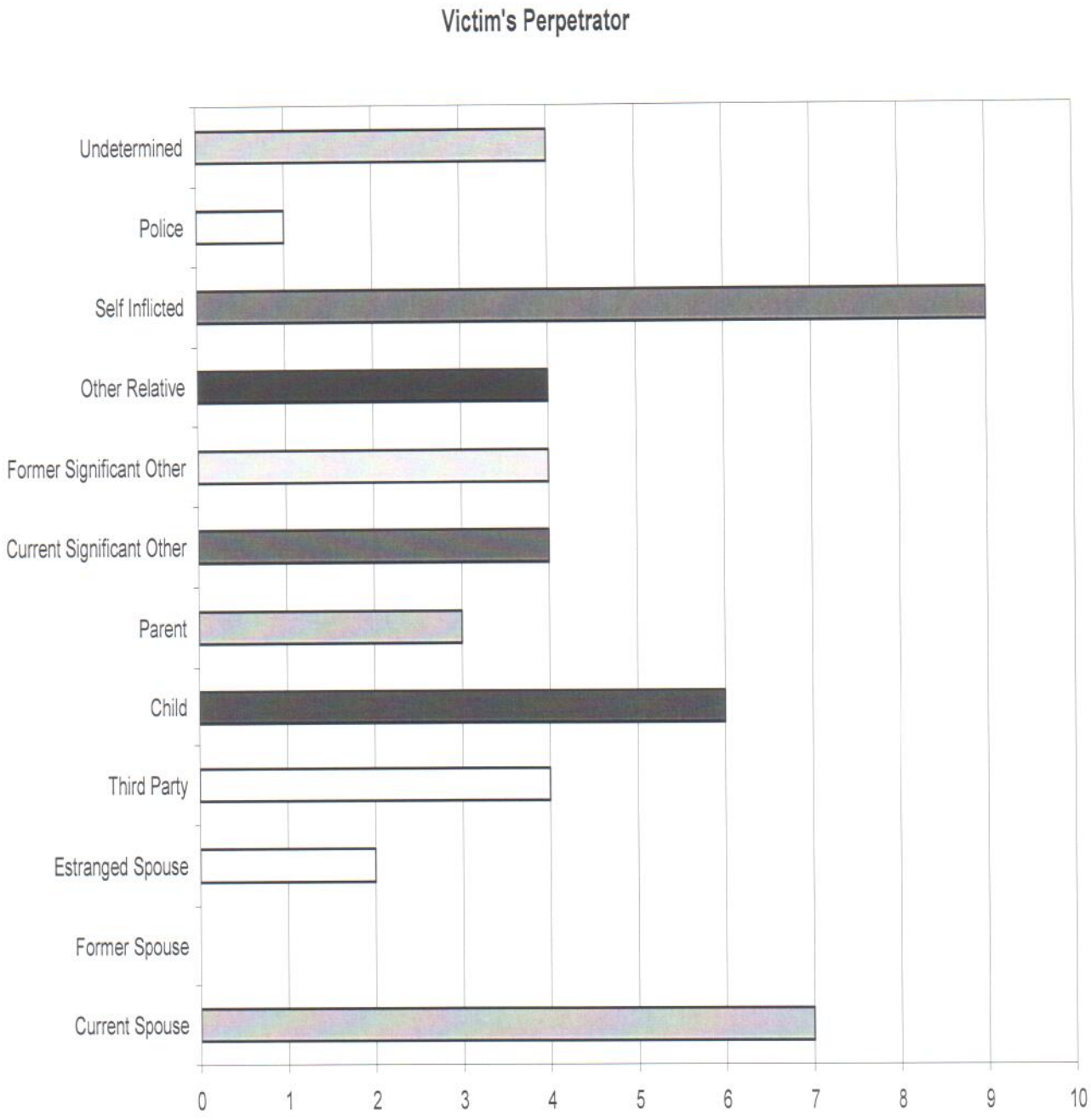
Race Of Victims



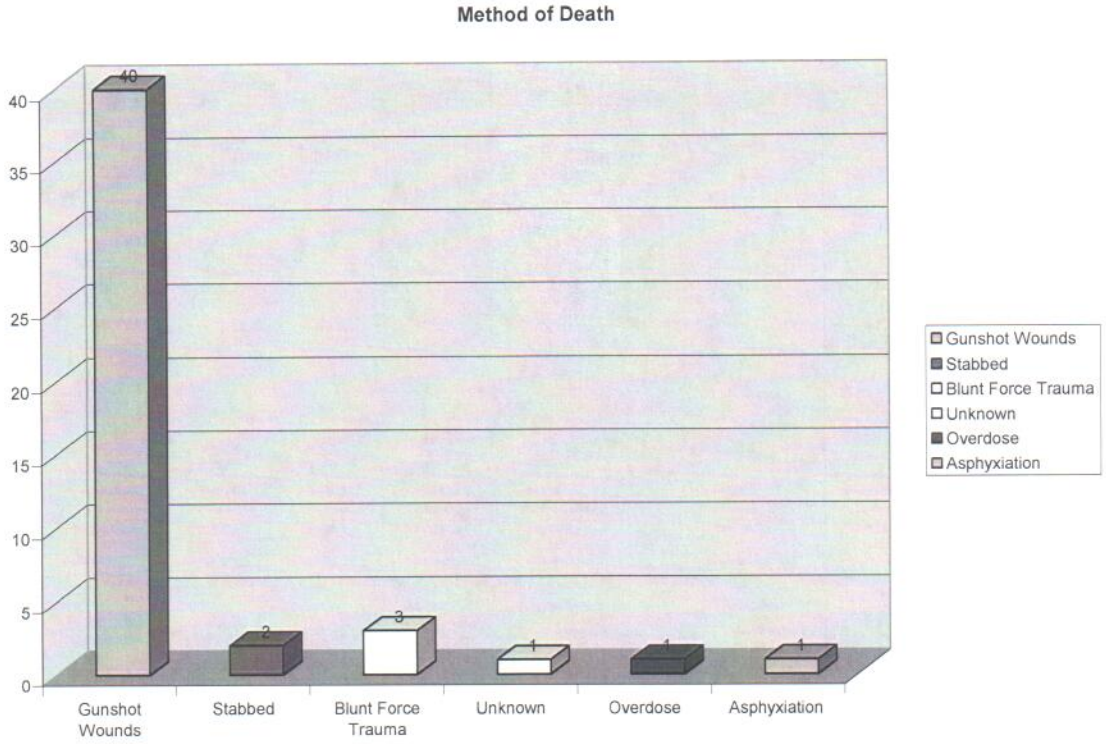
Age of Victims



The breakdown of victim's perpetrator's is broke down in the following chart. A further breakdown by intimate partner, familial death and other domestic violence related deaths will follow later in this report.



Of the forty-eight fatalities review, the method of death was gunshot wounds in 40 of the cases. Two fatalities resulted from stab wounds, three from blunt force trauma, one unknown, and one by overdose.

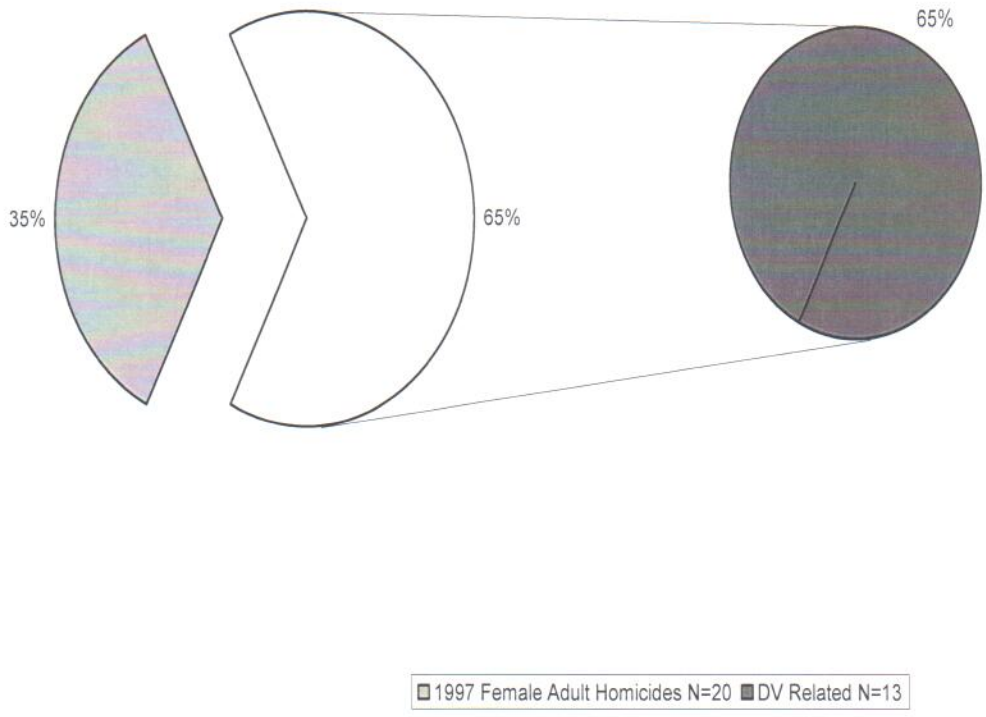


For the year 1997, West Virginia had a population on 1,816,000. Twenty-two of the fifty counties in West Virginia experienced at least one domestic violence fatality. A county by county break down follows, which clarifies how many deaths were attributed to each incident of domestic violence. To show a fair representation, each victim is counted individually in the chart below even when multiple victims occurred from one incident. For example, Ohio County had seven domestic violence related deaths, however six of them stemmed from one incident.

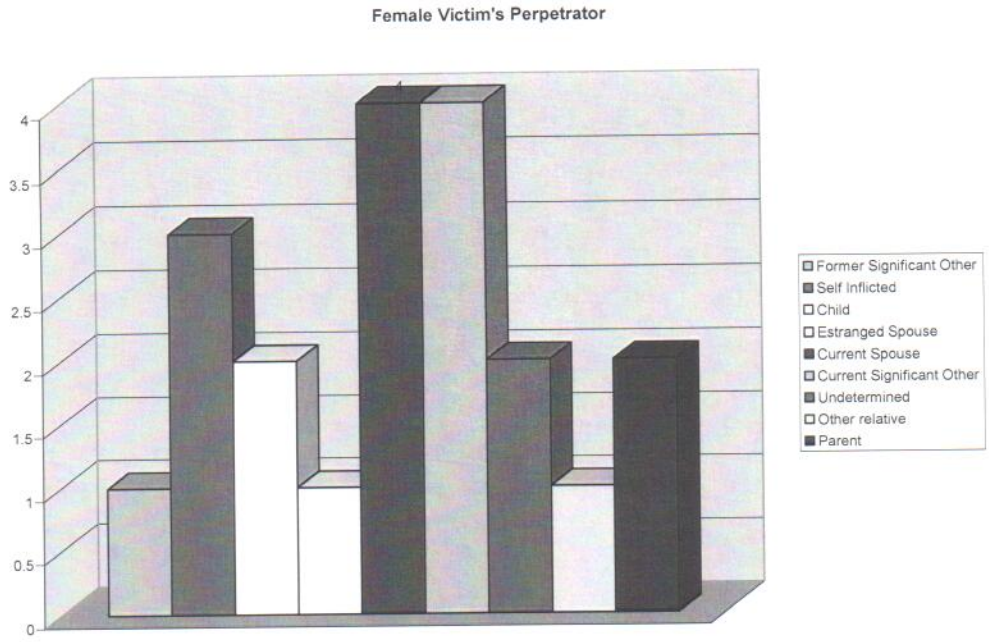
County	Deaths	Incidents
Berkeley	2	2
Boone	3	2
Brooke	3	2
Fayette	1	1
Greenbrier	1	1
Hampshire	4	1
Jackson	1	1
Kanawha	3	3
Lincoln	1	1
Logan	1	1
Marion	2	2
Marshall	1	1
Mercer	5	4
Mingo	3	3
Monroe	1	1
Nicholas	1	1
Ohio	7	2
Pocahontas	2	1
Putnam	1	1
Raleigh	1	1
Summers	2	1
Wayne	2	1
Total	48	34

There were a total of twenty female homicide victims for the year 1997. Out of these 20 homicides, thirteen were identified as domestic violence related. That is 65% of female homicides attributed to domestic violence; the national average is 30% percent of female homicides are domestic violence related according to the Bureau of Justice Statistics Factbook (1998).

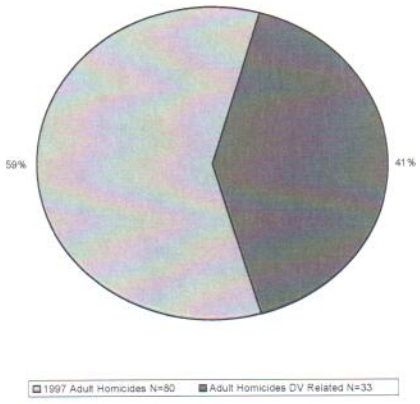
Percentage of 1997 Adult Female Homicides That Were Domestic Violence Related



Of female fatalities, the team reviewed a total of 20 cases for the 1997 calendar year. Thirteen of the deaths were homicides, three were suicides, all with a history of domestic violence, two were classified undetermined, and two were children that were killed by their father. Perpetrators of those female fatalities are outlined in the chart below.

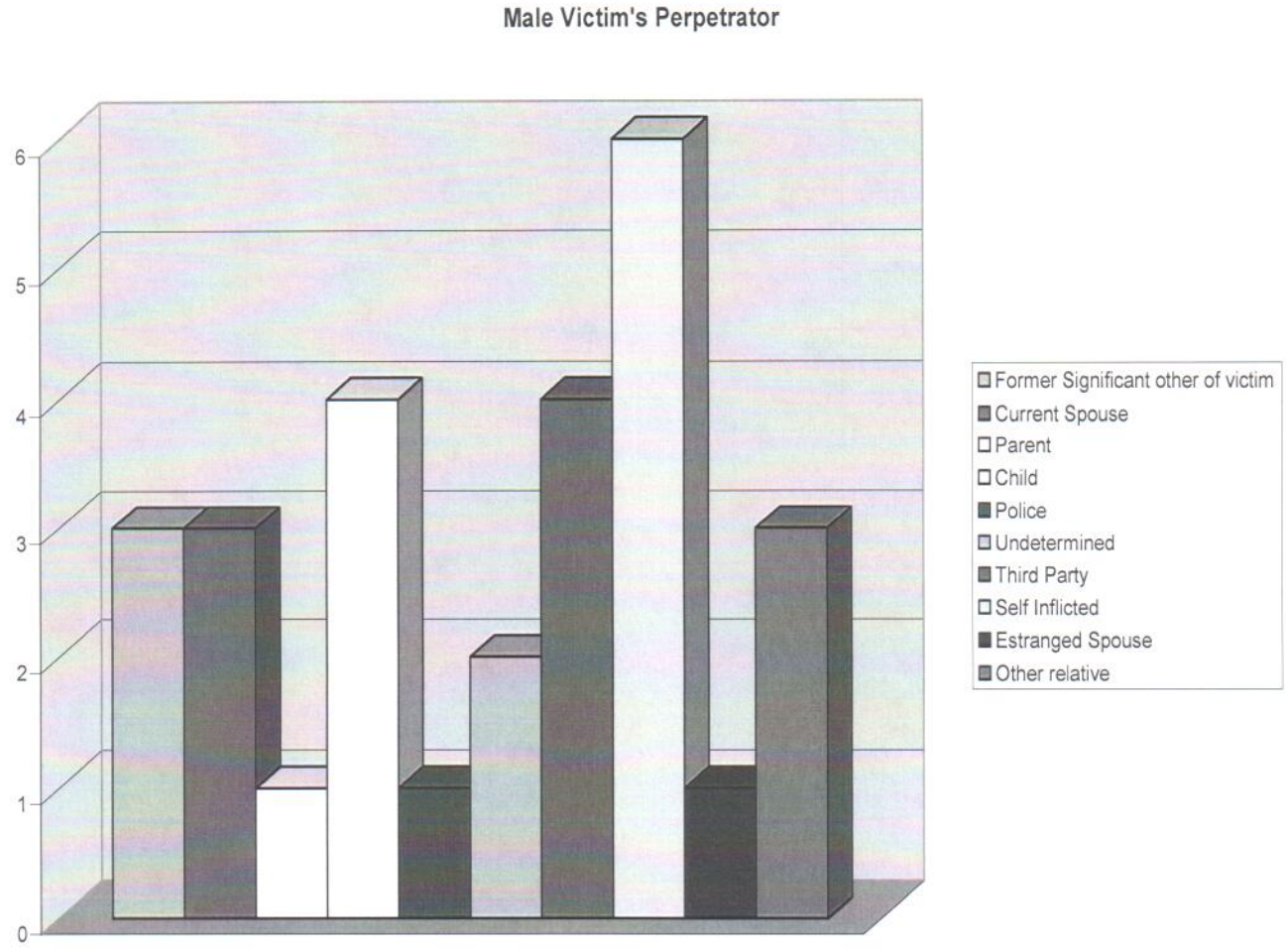


The total number of adult male homicides in West Virginia for 1997 was 60. Out of those sixty homicides, the DVFRT reviewed 20 that were attributed to domestic violence. This brings the total of domestic violence related fatalities to 33% of all male homicides, which is nearly half of that of female domestic violence related fatalities of which 65% were attributed. The total of all 1997 adult homicides that were domestic violence related was 33 of 80, which is 41%.



The DVFRT reviewed a total of 28 male fatalities. As stated prior, 20 of these were homicides, six were suicides, and two were classified as undetermined. Noteworthy at this point, four of the six suicides occurred at a time when the relationship was coming to an end. All four cases had prior domestic violence noted. The other two suicides both occurred after the perpetrator had killed his family. In one case the perpetrator killed his wife, his two small daughters, his mother and his brother before turning the gun on himself. In the other case, the perpetrator killed his father, grandmother, uncle, seriously wounded his cousin and then turned the gun on himself.

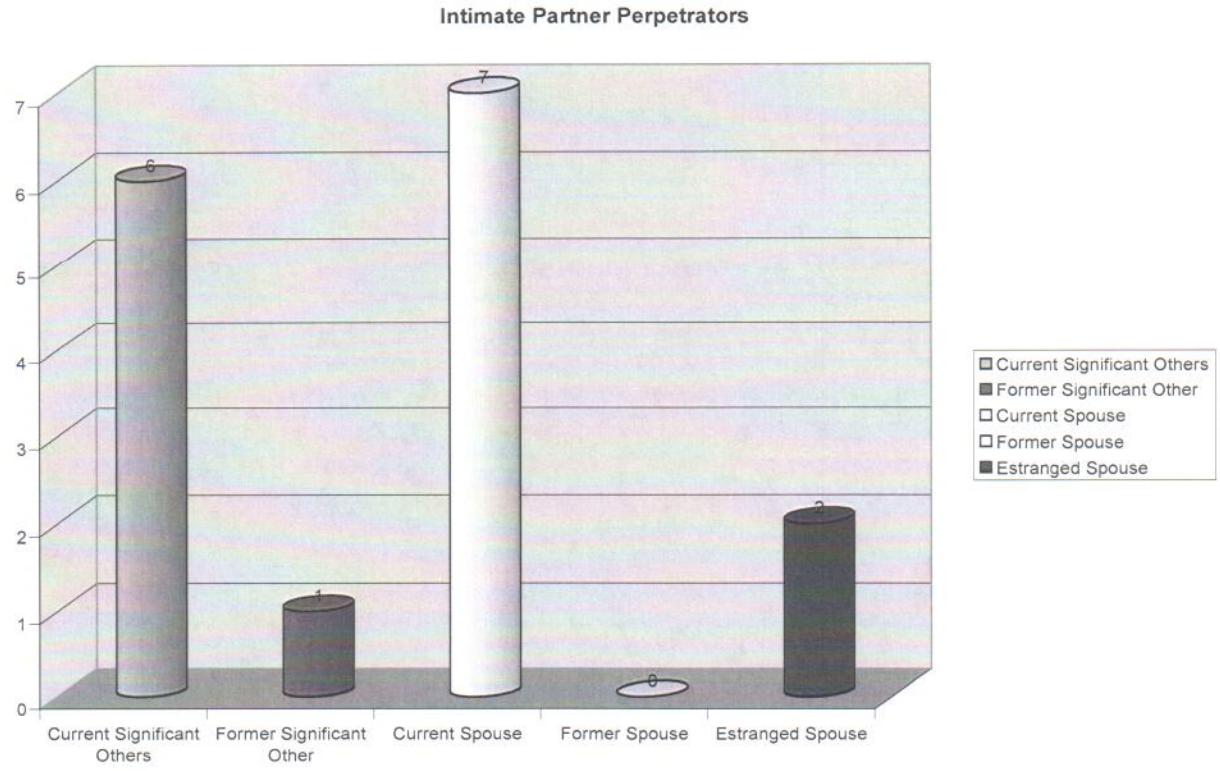
A breakdown of male victim's perpetrator is included in the chart below.



To further break the data down for review, the following charts break down the domestic violence related fatalities into intimate partner deaths, familial

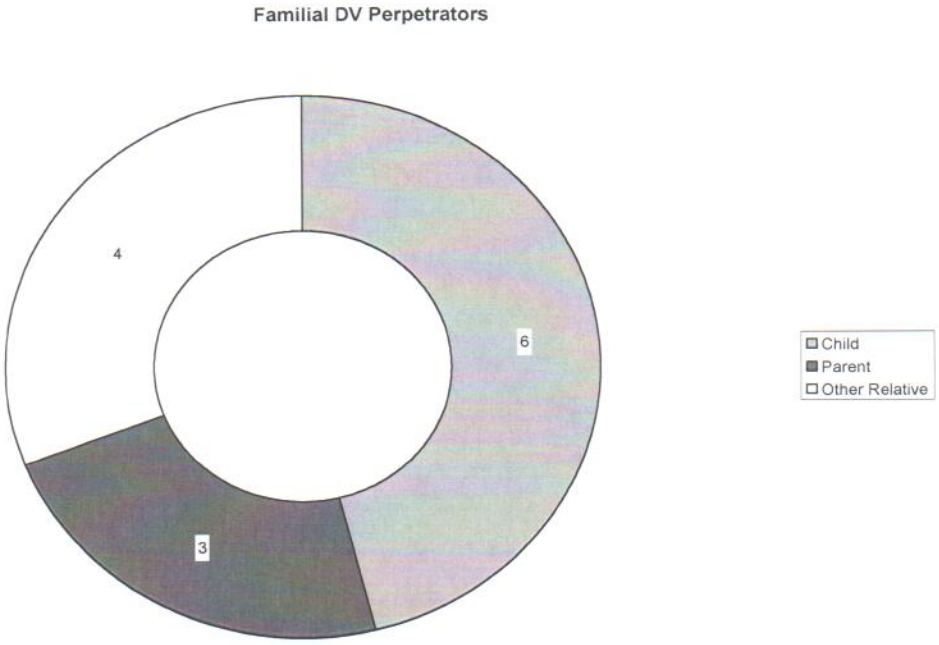
domestic violence deaths and other domestic violence related deaths by perpetrator. For purpose of clarification as defined in West Virginia Code §48-2A-2, an intimate partner is current or former spouses, current or former sexual partners, persons living as spouses, persons who have formerly resided as spouses, persons who are dating or have dated, persons who are presently residing or co-habitating or in the past resided or co-habitated together, or a person with whom the victim has a child in common. Family or household member include parents, children and step children, or other persons related by blood or marriage. Other domestic violence related deaths for purpose of this report include a third party, which can mean someone intervening in a domestic dispute, a current significant other or friend, suicides, or a police officer in the line of duty, that we have determined were domestic violence related but do not fit in the definition of domestic violence by West Virginia Code.

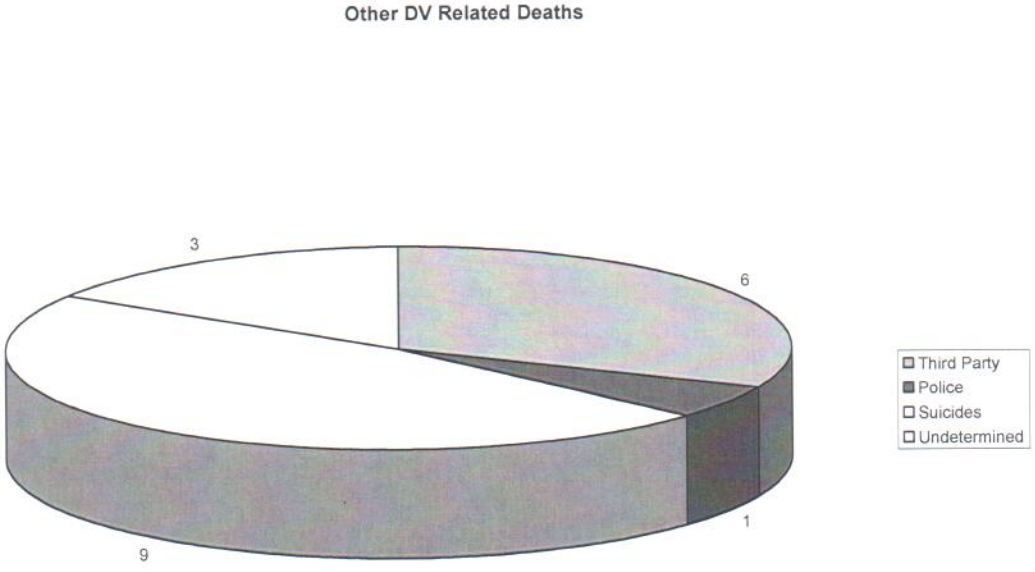
The DVFRT reviewed sixteen fatalities that were intimate partner deaths. Of these sixteen deaths, thirteen (84%) were killed by a current spouse or significant other. Two were killed by an estranged spouse and one by a former significant other.



Of the thirteen familial domestic violence related deaths, six were killed by a child and in all of these cases it was by a son or step-son. Three were killed by

a parent, two were children killed by their father along with their mother, grandmother and uncle and one was a mentally handicapped adult son, killed by his mother who then committed suicide. Four were killed by another relative, including a grandson, a nephew, a father –in-law and a brother.





A large percentage of our domestic violence related deaths, nearly forty percent would not have been attributed to domestic violence in any other repository that tracks domestic violence statistics. Nine of these cases were suicides that were directly related to domestic violence. One was a male who was killed by police officer who responded to a domestic call and had a stand off with for nearly two hours before he pointed his gun at the police and they were left no choice but to fire. Three deaths were classified undetermined by medical examiner and would not have been tracked as a domestic violence fatality. Of the six third party deaths, two males shot domestic violence perpetrators after they intervened in a domestic dispute, another came to the aid of a victim and was shot before the perpetrator shot himself. Three others were current boyfriends of women who had been abused by the perpetrators in the past.